North West **LHIN**

Better, Together

2010 – 2011 Annual Report

Ontario
Local Health Integration Network

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Message from the Chair

Janice Beazley

I am so pleased to present the 2010/2011 Annual Report. We have come a long way since that day six years ago, when the Local Health Integration Networks were created to address health care system needs from a local perspective.

I remember it like yesterday.

Sitting in an office in downtown Toronto, I'd just finished signing some official documents with all the other founding LHIN Board members from across the province. I remember thinking to myself: What is this going to look like?

I knew we had a big job to do – to protect but also transform our beloved publicly-funded health care system into something sustainable for the future.

I was honoured and humbled then, to be a part of a new beginning.
And I continue to be honoured and humbled today, as my time with the Board of the North West Local Health Integration Network (LHIN) draws to an end.

I'm most impressed with the new partnerships we have forged together with our health care providers, Aboriginal partners and other stakeholders as we strive to improve access to high quality health care for patients and clients in Northwestern Ontario.
Through candid conversations, we have started the critical process of looking at the regional health care system as a whole, not in isolated silos.

I'm also proud of our resilience and innovation.

As northerners, we've always had to think outside the box to survive. I know we will continue to do so, not just out of necessity – it's simply who we are and what we do.
This journey hasn't been without challenges. Change of any kind is difficult. But I truly believe that we all have the best interests of our patients and clients at heart.

And that's where our most important resource comes in: our people.
I would be remiss not to thank all the wonderful people I've worked with these past six years: Board and staff at the North West LHIN, health care providers, our stakeholders and community members.
It was a privilege to work with such dedicated, intelligent, passionate individuals, at all levels.

And finally, I'd like to congratulate the Ministry of Health and Long-Term Care for having the courage and foresight to develop a health care model that respects local health care input and decision-making.
It was the right thing to do then. It's the right thing to do now. A heart-felt thank you for your continued support of the LHIN-model.

So, to answer my question from six years ago: what is it going to look like, our health care system of the future?
Truly integrated. Evidence-based. Outcome-driven. Accountable. Transparent. With terrific results.
Are we there yet? No.
Are we getting there? Yes, because we are all working together to realize our vision: *Healthier people, a strong health system – our future.*
Better, together.

Janice D.A. Beazley, CHE
Chair

Message from the CEO

Laura Kokocinski

On behalf of the North West Local Health Integration Network (LHIN), I am pleased to share our 2010/2011 Annual Report. This document highlights our accomplishments, activities and financial results of the past year.

It's been a challenging, but rewarding twelve months. Together with our health care partners, we've accomplished a great deal.

The North West LHIN has:

- Reduced emergency department wait times;
- Exceeded provincial targets for surgery wait times for cancer, cataract and knee surgeries;
- Helped more seniors live safely at home, with dignity;
- Reduced the number of Alternate Level of Care patients waiting in hospital;
- Linked 33 percent more individuals with a family doctor or nurse practitioner;
- Provided more training to more people so they can manage their own health, all supported by teams of health care professionals;
- Worked with our Aboriginal communities to improve access to culturally-appropriate care;
- Made a formal commitment to members of our Francophone community to support access to health care in their own language; and
- Used information and communications technology to modernize the health system, to improve access to care and to improve patient and client safety.

These are very challenging times. Our population is aging. Across the system, we are all being asked to do more with less – to manage within our means.

That's why the North West LHIN's role as a system manager is more important than ever.

When the provincial government created the LHINs six years ago, we were given an important mandate: to plan, fund and integrate health care services to improve access to high quality care for all.

In other words, deliver the right care, at the right time, in the right place, at the right cost.

We do that together, through thoughtful, intelligent health services planning.

In June 2010, the North West LHIN began working on a Health Services Blueprint to provide new directions for care in our region over the next 10 years. It is informed through engagement, best practices and solid research.

We do that with wise investments. We continue to support programs and services that are patient-centred, evidence-based, and that demonstrate good value for money spent.

We do that with integration – as part of our mandate. Integration is necessary to ensure sustainability of quality health care in our region. The advantages and benefits are too great to ignore.

Under the LHIN leadership, support and encouragement, many of our health care partners are already working together in new ways.

We are witnessing collaboration and partnerships in governance, administration, clinical services and back office support, in ways we did not see in the past.

All of these examples of integration show how access to health care can be improved and efficiencies found, by working together. We have unique health care challenges in the north.

But we also have a history of working together, and that's never been more evident than this past year. People are willingly coming to the table – as a team, as system partners – to plan for the future. We need this spirit of cooperation to continue, so that together, we can fulfil our vision: *Healthier people, a strong health system – our future.*

Through partnerships, collaboration and teamwork, we will be...better, together.

Laura Kokocinski, BScN, MEd, CHE
Chief Executive Officer

Our LHIN, Our People

The North West LHIN covers 47% of Ontario's total land mass and is home to approximately 235,000 people according to the 2006 Census. That's just 2% of Ontario's population, making our population density of 0.5 people per square kilometre the lowest in the province. Our boundaries extend from just west of White River to the Manitoba border and from Hudson Bay in the north to the United States border in the south.

Portions of our population live in remote areas (the majority of whom are Aboriginal[1]) with road access only in the winter; others are accessible only by air year-round. Our communities are spread across almost 458,010 square kilometres which makes planning, delivering and accessing health services within the Northwest challenging. However, the relationships and innovation in our region create opportunities. Together with our partners, the North West LHIN will make the most of every opportunity as we work toward our vision: *Healthier people, a strong health system – our future*.

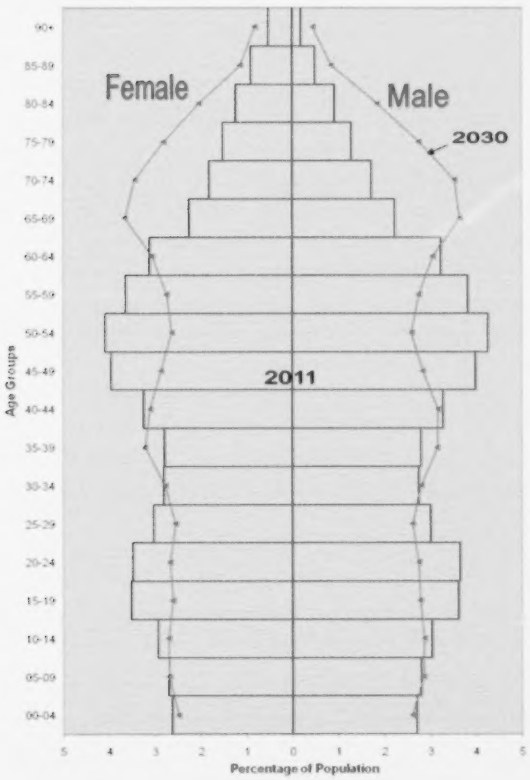
* The **Municipality of Greenstone** is an amalgamation of the former townships of Beardmore and Nakina, the towns of Geraldton and Longlac, and the communities of Caramat, Jellicoe, Orient Bay and MacDiarmid. The catchment area also includes the following First Nations communities: Long Lake #58, Ginoogaming, Rocky Bay, Sand Point, Lake Nipigon Ojibway (Animbiigoo-Zaagi'gan Anishinaabek), Poplar Point First Nation, and Aroland First Nation.

[1] Including First Nations, Métis and Inuit.

Our Population

According to the latest Ministry of Finance population estimates and projections, the North West LHIN's estimated population for 2009 was 238,245 and projected to be 237,460 for 2011, a 0.3% decrease. Between 2011 and 2030, the Ministry of Finance projects our population to slightly decline to 235,807 in 2030, a 0.7% decrease. Figure 1 shows the projected change in the age-sex distribution of the Northwest over this period.

Figure 1:
Projected Change in the North West LHIN Population 2011 – 2030



In the past, Northern Ontario's positive natural increase (births minus deaths) offset part of the losses it experienced through net migration (in-migration minus out-migration). However, the natural increase in the North as a whole is now negative and it is projected to remain so as population aging accelerates.

A 78% increase in the number of seniors (age 65 and over) living in the North West LHIN is projected between 2011 and 2030.

The following bullet points highlight some of the differences in the overall North West LHIN census population[2] for 2006 compared to the province.

- 19.2% of those in the Northwest self-identify as Aboriginal (adjusted with Indian and Northern Affairs Canada (INAC) data). This is the highest of the 14 LHINs and much higher than the provincial average of 2.0%.
- Of the North West LHIN residents who self-identify as Aboriginal, 15.3% are North American Aboriginal and 3.4% are Métis. However, we know this population is underrepresented in the census data.
- In the 2006 Census, the median age for Ontario residents reporting Aboriginal identity was 28 years compared to 38 years for non-Aboriginal residents.[3]
- The proportion of residents who are Francophone is slightly lower than the province as a whole (3.5% versus 4.4%).

Within the North West LHIN, there are variations between sub-LHIN areas and communities. Table 1 highlights some of the variation in census population characteristics of sub-LHIN planning areas across the North West LHIN.

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[2] Statistics Canada Census, 2006.

[3] First Nations Peoples in Ontario: A Demographic Portrait. Health Analytics Branch. Jan. 2009.

Table 1: 2006 Census Characteristics of North West LHIN Sub-LHIN Planning Areas

2006 Census Indicators	North West LHIN Sub-LHIN Planning Areas				
	Kenora District Area[1]	Rainy River District Area	Thunder Bay City (& Surrounding Area)	Thunder Bay District Area	North West LHIN
Population[1]	64,465[1]	21,565	122,905	26,155	235,095
% population age 65 and over	11.4%	16.1%	16.0%	11.4%	14.3%
% Population of Aboriginal Identity[2]	38.4%	21.7%	8.3%	19.9%	19.2%
% French-Speaking population	2.5%	1.7%	2.8%	10.8%	3.5%

Notes:
[1] Sub-LHIN area census analysis prepared by Health Analytics Branch, MOHLTC, August 2008 has been revised.
[2] Estimates of Aboriginal population in sub-LHIN planning areas have not been adjusted with INAC data.

Although the proportion of seniors in the North West LHIN is increasing and the overall population is stable or slightly decreasing, this is not the case with the Aboriginal population. The Aboriginal population in the North West LHIN is growing, and the population is younger.[4]

- Half (50%) the Aboriginal population in Kenora is under the age of 25, almost double the proportion of 27% for the non-Aboriginal population.
- The Aboriginal population living in the census agglomeration of Kenora is young and growing. In 2006, 2,365 Aboriginal people lived in Kenora, a 40% increase from 2001.
- Nearly half (48%) of Aboriginal people in the city of Thunder Bay are under the age of 25, compared to 28% of the non-Aboriginal population.
- The Aboriginal population living in the census metropolitan area of Thunder Bay is young and growing. In 2006, 10,055 Aboriginal people lived in the area of Thunder Bay, a 23% increase from 2001.

[4] 2006 Aboriginal Population Profile for Kenora and 2006 Aboriginal Population Profile for Thunder Bay. Statistics Canada. 2009.

Population Health Profile

According to the 2007 to 2009 Canadian Community Health Surveys of the North West LHIN regarding residents age 12 and over:

- A higher proportion of our residents report their health as "excellent" or "very good" (58.2%) in 2009 compared to 2007 (53.1%); now similar to the province as a whole at 61.2%.
- The proportion reporting their mental health as excellent or very good in the Northwest in 2009 is still lower than the province overall (68.3% compared to 74.0%).
- The proportion of residents age 12 and over that report being current smokers continues to be significantly higher than the provincial estimate (25.3% compared to 18.6%).
- Similarly, of those who drink regularly, the proportion of heavy drinkers (5 or more drinks on one occasion at least once a month over past year) remains significantly higher than the rest of the province (21.8% compared to 15.6%).
- The proportion of residents reporting being physically active during leisure time has improved between 2007 and

2009 from 52.4% to 60.1%. However, the proportion of residents age 18 and over that report being overweight or obese (based on self-reported height and weight) continues to be higher than the province (60.6% compared to 51.4%).

- The proportion of 12- to 17-year-olds who were obese or overweight in the North West LHIN in 2009 was lower compared to the province (15.5% compared to 20.9%).
- According to the most recent data (2009) from the Primary Care Access Survey (PCAS), 13.2% of North West LHIN residents age 16 and over are unattached (i.e. have no regular primary care physician) compared to only 7.0% for all Ontario residents age 16+.

Based on the most recent mortality data (2005 to 2007), differences between North West LHIN residents and all Ontarians include:

- Mortality rates (age standardized) for North West LHIN males are significantly higher than corresponding provincial rates for all causes combined (761.6/100,000 males compared to 640.8/100,000) and all circulatory system diseases (234.2/100,000 compared to 197.1/100,000).
- Of particular note is the fact that the Northwestern Ontario male mortality rates for unintentional injuries and suicide and self-inflicted injuries are 1.7 times and 2.3 times greater than the corresponding provincial rates (52.5/100,000 males vs. 31.6/100,000 for unintentional injuries and 27.7/100,000 males vs. 11.9/100,000 for suicide and self-inflicted injuries.
- Mortality rates (age standardized) for North West LHIN females are also significantly higher for all causes combined (518.4/100,000 females compared to 430.2/100,000) and all circulatory system diseases (138.9/100,000 compared to 122.9/100,000).
- Similar to the males, the female mortality rates due to unintentional injuries and suicide and self-inflicted injuries are 1.6 times and 3.4 times greater than the corresponding provincial rates (26.6/100,000 females vs. 16.1/100,000 and 13.5/100,000 vs. 3.8/100,000 respectively).
- The breast cancer mortality rate for North West LHIN females, however, is significantly lower than the provincial rate (15.5/100,000 females compared to 22.0/100,000).

Aboriginal Health

Based on the Canadian Community Health Survey (combined years 2005, 2007/08), some differences in health status and health behaviours were detected provincially between Aboriginal and non-Aboriginal populations age 12 and over:

- Lower proportion of Aboriginal population perceived their health as very good or excellent (52% vs. 61%).
- Lower proportion of Aboriginal population perceived their mental health as very good or excellent (66% vs.75%).
- Approximately double the proportion of Aboriginal population reported being a current smoker compared to non-Aboriginal population (40% vs. 20%).
- Higher proportion of Aboriginal population reported heavy drinking (5 or more drinks on one occasion at least once a month over past year) at 23%, compared to non-Aboriginal population (16%).

Francophone Health

Based on the combined years of the Canadian Community Health Survey (2005 & 2007), the following prevalence estimates are reportable for North West LHIN Francophones age 12 and over:

- 55% of the Francophone population age 12+ perceive their health as very good or excellent.
- 67% perceive their mental health as very good or excellent.
- Just two-thirds (64%) reported that they have a regular medical doctor,

significantly lower than the non-Francophone population in Northwestern Ontario (85%), and only 60% reported that they had contact with a medical professional in the past 12 months.

Number of Health Care Facilities and Programs Funded by the North West LHIN

As of April 1, 2007, the North West LHIN assumed responsibility for funding the following:

Community Care Access Centre	1
Community Health Centres (1 with 2 satellites)	2
Community Mental Health and Addictions Services	36
Community Support Services	63
Long-Term Care Homes	14*
Hospitals	13
Total number of Health Service Provider (HSP) programs or operations	129
Total number of HSP organizations	97**

** Note: Service Accountability Agreements are in place for all LHIN-funded programs including long-term care operators.*

***This represents the number of individual Health Service Providers (HSPs) funded by the North West LHIN. Some HSPs funded by the North West LHIN provide service in multiple sectors but are only counted once for the purpose of this report.*

Board of Directors

The North West LHIN is governed by an appointed, skills-based Board of Directors, accountable – through the Chair – to the Minister of Health and Long-Term Care for the LHIN's use of public funds, for achieving results through execution of its strategic directions and for performance of the local health system.

Directors are appointed by Order-in-Council for a term of one to three years, subject to a six-year maximum. As of March 31, 2011, the North West LHIN had its full complement of nine Directors.

2010-2013 Strategic Directions

The North West LHIN Board of Directors' Strategic Plan *2010-2013 Leading Health System Transformation in Our Communities* provides a common vision and common directions to the LHIN and health service providers for the health system until 2013.

Four strategic directions are outlined in the plan:

1. Improved health outcomes resulting in healthier people.
2. Access to health care that people need, as close to home as possible.
3. Continuous quality improvement.
4. Well-managed resources.

As the North West LHIN works together in partnership with its health service providers to achieve the goals in the strategic plan together, positive changes will take place to improve people's health and care experiences, and to better utilize and manage available resources.

Our Mission

Develop an innovative, sustainable and efficient health system in service to the health and wellness of the people of the North West LHIN.

Our Vision

Healthier people, a strong health system – our future.

Our Values

1. Person-Centered
2. Culturally Sensitive
3. Sustainable
4. Accountable
5. Collaborative
6. Innovative

The North West LHIN uses the Triple Aim Framework to support quality improvement in LHIN activities and health system redesign.

- In the past year, a comprehensive evaluation of all Aging at Home initiatives was completed and initiatives were assessed according to impact on improving population health, patient care experience and value for money.

Janice Beazley
Chair

Bob Gregor
Vice Chair

Joy Warkentin
Vice Chair

Ennis Fiddler
Secretary

Kevin Bähm
Director

Dennis Gushulak
Director

Dianne Miller
Director

Judy Morrison
Director

Gary Phillips
Director

Tom Sarvas
Director

Name	Current Position	Location	Term
Beazley, Janice	Chair	Fort Frances	June 1, 2005 to May 31, 2008 Reappointed to August 20, 2011
Gregor, Bob	Vice Chair	Marathon	May 17, 2006 to May 16, 2008 Reappointed to May 16, 2011
Warkentin, Joy	Vice Chair	Thunder Bay	November 18, 2009 to January 26, 2013
Fiddler, Ennis	Secretary	Sandy Lake	June 1, 2005 to May 31, 2008 Reappointed to June 15, 2011
Bähm, Kevin	Director	Terrace Bay	January 5, 2006 to January 4, 2008 Reappointed to January 30, 2011
Gushulak, Dennis	Director	Ear Falls	July 28, 2010 to July 27, 2013
Miller, Dianne	Director	Thunder Bay	November 18, 2009 to November 17, 2012
Morrison, Judy	Director	Fort Frances	May 17, 2006 to June 16, 2007 Reappointed to June 16, 2010
Phillips, Gary	Director	Thunder Bay	November 18, 2009 to November 17, 2012
Sarvas, Thomas (Tom)	Director	Thunder Bay	April 2, 2008 to April 1, 2011

Integrated Health Services Plan (IHSP)

Priorities for Change to the Health Care System in Northwestern Ontario

The North West LHIN is currently operationalizing the strategic directions of the Board through the implementation of the goals identified in the first year of the *Integrated Health Services Plan (IHSP) 2010-2013*.

The IHSP was developed through information gathered at community engagement activities, including education sessions, roundtables and the important work of the North West LHIN's many advisory teams, as well as through data collection, data interpretation and analysis.

The 11 local and provincial priorities in the 2010-2013 IHSP focus on three areas: Access to and Integration of Services, Enablers, and People of Northwestern Ontario, as outlined below.

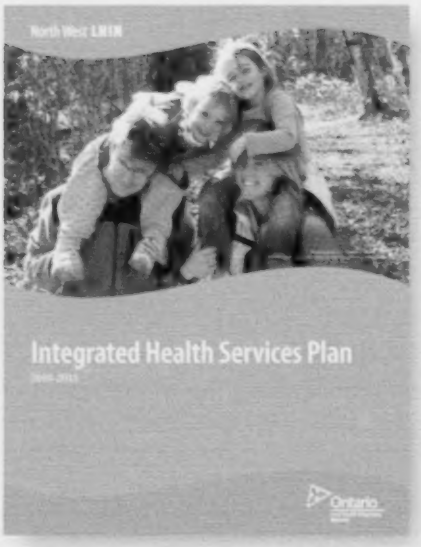
Access to and Integration of Services

Emergency Department Wait Times & Alternate Level of Care
Primary Care
Specialty Care & Diagnostic Services
Chronic Disease Prevention and Management
Long-Term Care Services
Mental Health & Addictions Services

Enablers

Health Human Resources
eHealth
Integration of Services along the Continuum of Care

People of Northwestern



Ontario

Aboriginal Health Services
French Language Health Services

Health System Advancements in 2010/11

The *Integrated Health Services Plan (IHSP) 2010-2013* is a high level plan that builds on the findings and accomplishments of the first IHSP, which guided activities from 2007 to 2010.

Here is a summary of the key issues and the progress made this past year in each of the 11 priority areas included in the 2010-2013 IHSP:

Emergency Department Wait Times & Alternate Level of Care

This past fiscal year, the North West LHIN invested more than $5.3 million towards 42 initiatives that supported community-based services for all individuals across our region, in order to help avoid unnecessary visits to the emergency department, hospitalization and to help expedite discharge from hospital.

Reducing emergency department (ED) wait times and Alternate Level of Care (ALC) are top priorities. The North West LHIN's goal is to improve access to health care at all levels, so that patients can transition across the system in a seamless, coordinated, integrated and timely manner.

The percentage of Alternate Level of Care in the North West LHIN is the second highest in the province at 22.67 percent. Limited access to after-hours primary care and limited community support services (e.g. supportive housing, assisted living, homemaking and transportation options) contributed to increased ALC days in many of the smaller northern community hospitals across the region.

Over the past year, the North West LHIN completed an in-depth analysis of short- and long-stay ALC patients to assess the care needs of the patient population. The current ALC definition does not work for our small rural community hospitals where occupancy rates are low, community support services are limited – and the only option for care (rehab, complex continuing care, convalescence, palliative) is at the hospital.

Further, in the last six months of 2010/11, health care partners in Thunder Bay worked together with the LHIN to achieve the necessary system changes within respective organizations that will reduce Alternate Level of Care days by 50 percent.

To address the ALC issue, the North West LHIN invested in:

- New community support services for 450 seniors and elders in Aboriginal communities;
- Expansion of supportive housing services across the Northwest region through the introduction of 110 new supportive housing units and assisted living services for seniors (75 units in Thunder Bay, 10 in Rainy River, 20 in Kenora and five in Dryden), bringing the full complement of supportive housing and other assisted living services in the Northwest to 408; and
- Increased assisted living capacity in the region by 37 percent through enhanced services to 200 existing supportive housing units and assisted living services in the City of Thunder Bay (24/7 support to seniors in their homes).

The North West LHIN also increased funding for homemaking services offered by the North West Community Care Access Centre (CCAC) through the Wait at Home and Intensive Case Management programs. Alternate Level of Care successes include:

- Decreased the number of ALC patients in the City of Thunder Bay by 33 percent since implementation of the Home First philosophy in October 2010;
- Decreased the number of ALC days in hospital for patients waiting for rehabilitation, complex continuing care and long-term care;
- More consistently applied the ALC definition across high-volume hospital sites;
- Reduced wait times for CCAC in-home care services by 23 percent across the Northwest; and

- Decreased the long-term care wait list by 15 percent between January 2009 and June 2010, from 600 to 500 individuals.

To address the issue of emergency department wait times, health service providers have been streamlining and standardizing triage, admission and coding processes across the region.

- In 2010/11, greater than 90 percent of non-admitted patients were discharged from the emergency department in less than eight hours.

The Emergency Department Pay for Results (P4R) initiatives at the Thunder Bay Regional Health Sciences Centre (TBRHSC) have contributed to:

- Improved laboratory turnaround times in the emergency department; and
- Improved emergency department wait times for both low and high acuity patients, (6.6 hours and 4.1 hours respectively) – one of the best performers in the province.

In 2010/11, the North West LHIN advanced recommendations of the *Regional Emergency Department Study* as follows:

- Developed a collective vision for emergency departments;
- Supported use of a standardized a template for medical directives;
- Facilitated agreement amongst the majority of hospitals to adopt common evidence-based orders for admitted patients;
- Developed and distributed coding and triage reference guidelines to facilitate standardization of coding practices in emergency departments across the North West LHIN; and
- Supported the e-Credentialling project in development at TBRHSC. e-Credentialling will help expedite the process of physician credentialling, as we are heavily reliant on locum coverage for the emergency departments throughout the North West LHIN.

Primary Care

Primary care plays a vital role in – and is often referred to as the backbone of – the health care system. Access to primary care is an issue in the North West LHIN; approximately 25,333 people in Northwestern Ontario do not have a regular family doctor.[5] This is the highest number of unattached patients, per capita, in the province.

In an effort to increase the number of individuals with a primary care provider (physician or nurse practitioner), the Health Care Connect program (operated by the North West Community Care Access Centre), allows patients to self-refer, and works to match patients to providers who may be opening a new practice or taking on additional patients. Attempts are made to first match those who are the most complex and vulnerable.

By the end of 2010/11, 33 percent of individuals registered to the program were linked to a primary care provider. To date, almost all individuals registered for the program are from the Thunder Bay and Kenora catchment areas.

Access to interprofessional care teams is recognized as a necessary component of quality health care. Examples of interprofessional teams in the North West LHIN include: Community Health Centres,

[5] Primary Care Access Survey, 2009.

Aboriginal Health Access Centres and other group practice models in the primary care sector. With the addition of Family Health Teams (FHTs) and Nurse Practitioner-Led Clinics, individuals in our region will have improved access to interprofessional care teams.

Mobile and outreach models of primary care are also effective in improving access to interprofessional care teams. The NorWest Community Health Centre is piloting a mobile service in nine Thunder Bay District communities to enhance access to care for people who are at risk of developing diabetes.

A nurse-led outreach team provides education and supportive services to five long-term care homes in Thunder Bay. Through this initiative in 2010/11, there was an 80 percent increase in nurse practitioner visits to long-term care, a decrease in transfers to the emergency department, with less than 50 percent of the clients being admitted to hospital.

Successes of the past year include:

- The Lakehead Nurse Practitioner-Led Clinic rostered more than 1,800 patients since it opened in November 2010;
- Nipigon FHT began to roster patients this year;
- Harbourview Family Health Team in Thunder Bay was announced in 2010/11; and
- Manitouwadge FHT is scheduled to open in 2011/12.

Speciality Care & Diagnostic Services

The North West LHIN performed well against the provincial targets in most publicly-reported wait time categories.

There were some improvements in diagnostic imaging, where wait times are among the shortest in the province. For example, Computerized Axial Tomography (CAT) scan wait times have decreased to 25 days from 28, one of the best in the province. Although wait times for Magnetic Resonance Imaging (MRI) scans are above the provincial target at 86 days, the North West LHIN is the 4th best performer in Ontario.

Surgical wait times for cancer (37 days) makes the North West LHIN a top performer in the province; we are below the provincial targets for cataract (86 days) and hip (171 days) surgery, and close to the provincial target for knee surgery (183 days). Investments were made this year to support additional joint replacement surgeries in Thunder Bay and the Rainy River District.

The North West LHIN continues to support various telemedicine initiatives, such as: tele-psychiatry, tele-ophthamology, stroke management, cardiac rehabilitation and tele-rehabilitation.

The North West LHIN is one of the highest users of telemedicine, providing services to smaller rural and remote northern communities and to support care close to home. Approximately 20,000 visits occur through telemedicine each year in the North West LHIN.

Here is a breakdown of the percentage of telemedicine visits by speciality area:

- Physician speciality - six percent
- Surgery – nine percent
- Internal medicine – 11 percent
- Psychiatry mental health – 41 percent
- Oncology – 12 percent
- All other - 21 percent

In 2010/11, the North West LHIN tested the Moderate Surge Capacity Plan as part of its pandemic disaster planning process. The plan has now been finalized. The Electronic

Intensive Care Unit (eICU) consultation service, which is part of the Moderate Surge Capacity Plan, will be implemented in 2011/12. As part of the plan, the North West LHIN will continue to work on finding solutions to the challenges of transportation and repatriation of patients.

Chronic Disease Prevention & Management

The implementation of the Ontario Diabetes Strategy is an important focus in the North West LHIN as part of its Chronic Disease Prevention & Management strategy. We supported regional planning for chronic disease management in a number of areas including chronic kidney disease, cardiovascular disease, diabetes and dementia care. Specifically, the North West LHIN has worked with the Ontario Diabetes Strategy team provincially to implement changes that will lead to better outcomes for people with diabetes. Examples include:

- Improved screening by 10 percent for people with diabetes, leading to earlier intervention and fewer complications;
- Improved access to primary diabetes care for more than 125 people in nine communities through the high risk mobile unit operated by the NorWest Community Health Centre;
- Established a regional coordinating centre for diabetes care through the Northern Diabetes Health Network;
- Expanded service in Dryden and Longlac offered by the Northern Diabetes Health Network; and
- Supported coordination of chronic disease self-management programs.

A Targeted Approach to Improved Diabetes Management

In the spring of 2010, the Ministry of Health and Long-Term Care launched a provincial initiative called the Baseline Diabetes Dataset Initiative (BDDI). BDDI is a tool that provides primary care physicians with valuable information to support care of patients with diabetes. There are three key tests that people living with diabetes should receive on a regular basis: blood glucose, cholesterol, and a retinal eye exam.

The BDDI provides physicians with a baseline and regular reporting on the number of clients being tested in their practices. In 2010/11, 33.4 percent of patients with diabetes in the North West LHIN received all three tests in the appropriate time frame.

Chronic Disease Self-Management

The North West Community Care Access Centre, in collaboration with St. Joseph's Care Group, became the lead organization for chronic disease self-management programs in the North West LHIN. A full-time coordinator facilitates easy access to self-management programs across the region and supports the development of clinicians and community self-management practitioners.

The Ontario Diabetes Strategy has subsequently provided support for self-management activities across the province.

Long-Term Care Services

Aging at Home

In Year Three (2010/11) of the Aging at Home (AAH) Strategy, the North West LHIN received $3,241,065 to fund local programs that provided additional capacity for seniors services, helped seniors avoid hospital admissions and return home safely after a hospital stay, created enhanced community support services, and developed outreach teams.

The North West LHIN's Aging At Home Strategy is aligned with the Board's strategic objectives.

All too often, seniors wait in hospitals or enter long-term care homes with health care needs that could be safely addressed in their own homes with proper community support services. The "Setting the Balance of Care in Northwestern Ontario" studies found that of the individuals waiting for facility placement in the region, 40 percent were "low needs" clients that could be cared for in the community.

Further, the study found that eight percent of individuals "at risk" of institutionalization in Thunder Bay and 49 percent of wait-listed individuals in the surrounding region could potentially be supported – safely and cost effectively – in the community if given access to coordinated packages of home and community care services.

In 2010/11 to address long-term care needs, the North West LHIN:

- Created additional foundational capacity for community support services in Terrace Bay, Schreiber and Marathon;
- Funded the First Link program offered by the Alzheimer Society of Thunder Bay;
- Enhanced and expanded respite services in the District of Thunder Bay, Kenora and Rainy River, providing almost 18,000 hours of respite to more than 100 caregivers;
- Increased assisted living services for high risk seniors by 30 percent, serving an additional 116 clients;
- Established 75 units of transitional supportive housing in the City of Thunder Bay;
- Established 35 additional units of supportive housing service capacity in Kenora, Dryden and Rainy River;
- Continued funding for the North West Community Care Access Centre's System Navigator position which assisted more than 275 seniors in five apartment buildings in the City of Thunder Bay;
- Continued funding for the North West CCAC's Intensive Case Management program which supported seniors to stay at home in the community. This resulted in a 26 percent reduction in long-term care admissions and saved approximately 780 hospital days over the past 17 months; and
- Supported the Smooth Transitions program which safely discharged 850 seniors from hospital, and provided more than 5,000 hours of service in the community until appropriate longer term services could be implemented.

Because of these investments in community support services for seniors in our region, the North West LHIN was well-positioned to implement the Home First philosophy, a collaborative health system approach to ensure patients – mostly seniors – receive the health services they need upon discharge from hospital, in the most appropriate setting.

The North West LHIN began implementation of the Home First philosophy in Thunder Bay in late fall of 2010/11, in partnership with the North West Community Care Access Centre, the Thunder Bay Regional Health Sciences Centre and St. Joseph's Care Group. The number of Alternate Level of Care patients waiting in hospital decreased by 8.5 percent during the last three months of 2010/2011.

Falls Prevention

The North West LHIN was actively involved with the falls prevention program this past year.
For example, 36 teams from a variety of health care settings participated in the celebration and wrap-up in March, 2011, of the North West LHIN-Wide Falls Injury Prevention Collaborative.

Red Lake's Margaret Cochenour Memorial Hospital achieved a 60 percent reduction in falls, and community-based home support services like Saint Elizabeth Health Care now conduct falls' assessments on all admissions – considered to be leading practice.

Residents First, a quality improvement initiative in long-term care homes offered by the Health Quality Ontario (formerly Ontario Health Quality Council), built upon the work of the North West LHIN-Wide Falls Injury Prevention Collaborative.

Participating organizations received targeted education sessions in quality improvement methodology and have now adopted evidence-based practices in falls prevention and management.

The right care,
At the right time,
In the right place,
At the right cost.

Centre of Excellence for Integrated Seniors' Services (CEISS)

Work continued this past fiscal year on the Centre of Excellence for Integrated Seniors' Services (CEISS). Planning is underway for the 132 new supportive housing units that will be available for occupancy in the fall of 2012, and by 2013, CEISS will be home to 544 residents, including 64 behavioural beds for seniors who require specialized care.

Expanded and/or enhanced community support services from annualized investments, phased in over 2008/09 and 2009/10, were continued in 2010/11 for various community-based programs, including supportive housing, respite, meals programs, home help and home maintenance services.

In addition, the Network of Individualized Community Enhancements (NICE) funding through CEISS was accessed by several community health service providers in Thunder Bay to fund extraordinary one-time costs, which helped avoid placement in hospital or long-term care.
Finally, as part of the transition strategy for the 132 new supportive housing units at CEISS, funding was provided for up to 75 transitional supportive housing units at McKellar Place in 2010/11.

Mental Health & Addictions Services

The North West LHIN is committed to improving access to mental health and addictions services by making the system easier to navigate through better coordination and integration of services.

The North West LHIN is aligned with the provincial 10-year Mental Health and Addictions Strategy. Over this past fiscal year, we established 16 supportive housing units for people with problematic substance abuse in Thunder Bay, as well as eight units in Kenora and another eight in Fort Frances.

The North West LHIN also provided additional funding for psychiatric sessional fees to community mental agencies in Kenora/Rainy River, the District of Thunder Bay and the City of Thunder Bay. As a result, psychiatrists have been able to provide education, case conferences, client-centred, staff-centred and program-centred consultation, program direction and system coordination to a large number of agencies.

The Getting Appropriate Personal and Professional Supports (GAPPS) program, a three-year pilot project in Thunder Bay, exceeded targets for client contacts and registrations. The program provides an integrated approach to outreach, engagement, support, system navigation and clinical services to vulnerable persons with serious, unstable and complex mental illness, addictions and health issues.

In the past fiscal year, the GAPPS program:

- Registered 463 clients (target was 300);
- Made 2,107 contacts with registered clients and 2,204 contacts with clients who were not registered in the program (target was 1,500); and
- One alcohol and drug withdrawal management program saw a 49 percent reduction in clients sent to the emergency department.

The North West LHIN enhanced community outreach capacity and service coordination for residents with an acquired brain injury by providing $715,000 in new funding to the Brain Injury Services of Northern Ontario (BISNO).

In 2010/11, BISNO funded:

- A Family Therapist and Intake Coordinator in Thunder Bay;
- A Facilitator and Team Leader to the Healthy Lifestyles Group in Thunder Bay; and
- A District Facilitator in Sioux Lookout, Dryden, Fort Frances and on the North Shore area of Lake Superior, to manage high referrals and volumes.

Aboriginal Health Services

The North West LHIN is committed to ongoing engagement and health planning with Aboriginal stakeholders, communities and health service providers. The objectives are to improve access to quality health care, to establish mutually respectful relationships with First Nations communities, and to

improve the delivery of services to Aboriginal people across the continuum of care in a way that is both culturally and linguistically accessible and appropriate.

The North West LHIN worked with its Aboriginal Health Services Advisory Committee to receive ongoing advice about the health needs, planning priorities and service delivery issues affecting Aboriginal people and communities in Northwestern Ontario.

Over the past year, the North West LHIN:

- Participated in a public health pilot project with the Kenora Chiefs Advisory;
- Invested in additional community support services, like meals, homemaking, transportation and home maintenance to serve 450 elders in 34 Aboriginal communities;
- Hosted four diversity sessions for 263 participants in Sioux Lookout, Fort Frances, Nipigon and Thunder Bay;
- Hosted two Aboriginal Health Directors' meetings to share LHIN updates and receive information and feedback on health planning priorities; and
- Provided funding to four Aboriginal organizations and one non-Aboriginal organization to support education initiatives related to mental health and addictions for First Nations communities in the North West LHIN.

Members of the North West LHIN Board and Senior Leadership team met regularly with Aboriginal organizations and communities to discuss health care issues and opportunities for integration.

Centre of Excellence for Aboriginal Health Care

A highlight of the past year was the grand opening of Sioux Lookout's new Meno Ya Win Health Centre. Meno Ya Win means health, wellness and well-being – a state of mental, emotional, physical and spiritual wholeness.
Declared a Centre of Excellence for Aboriginal Health Care by the Ministry of Health and Long Term Care, it is the first provincial/federal health centre in Canada to exist through a Four Party agreement with Health Canada, the Province of Ontario, Nishnawbe-Aski Nation and the Municipality of Sioux Lookout.

The state-of-the-art facility is 140,000 square feet, with 60 in-patient beds and 300 employees. It provides health services to all residents within the community of Sioux Lookout and the surrounding area, as well as Nishnawbe-Aski Nation communities north of Sioux Lookout, Treaty #3, and residents of Pickle Lake and Savant Lake.

As a Centre of Excellence, the Meno Ya Win Health Centre serves as a role model for the delivery of both culturally-sensitive and holistic health care, merging traditional with modern healing practices.

French Language Health Services

As the system planner and manager of the local health system, the North West LHIN is accountable to ensure the availability of French language health services in our geographic area, and the integration of the principles of the French Language Health Services Act (FLSA) in our Integrated Health Services Plan (IHSP).

In the last year, the Ministry of Health and Long-Term Care transferred the role of the French Language Services (FLS) Coordinators to the LHINs. The North West LHIN FLS Coordinator provides support in planning, reporting, monitoring and integration of FLS within the health system in our region, and supports the LHIN in meeting its FLS obligations as a Crown agency.

In addition, the Local Health System Integration Act 2006 called for the creation of French language health planning entities to advise LHINs on Francophone community engagement.

On June 29, 2010, the Réseau du mieux-être francophone du Nord de l'Ontario was named the French Language Health Planning Entity for the North West and North East LHINs.

In March, 2011, the two LHINs signed an unprecedented funding and accountability agreement with the entity. This marked an important milestone towards ensuring that the unique needs of the Francophone people in the region are met. Joint planning with the Entity, the North West and North East LHINs will commence in 2011/12.

In the past year, the North West LHIN:

- Completed a comprehensive environmental scan of existing Francophone health services, with a Health Service Provider FLS inventory;
- Completed the FLS compliance assessment; and
- Ensured that LHIN documents are available in French.

Health Human Resources

The North West LHIN is working with its health care partners to explore ways to maximize the use of current health human resources – and to plan for future needs – because human resources are pivotal to health care delivery. The North West LHIN embarked upon the development of a comprehensive Health Services Blueprint, a plan that will identify future models of health care delivery, opportunities for integration, and project the demand and capacity for health services and resources, including planning priorities, for the North West LHIN out to 2021. This 10-year health human resources plan will be one of the deliverables of the Health Services Blueprint.

Together with our health service providers, and partners like the Northern Ontario School of Medicine (NOSM), Lakehead University, Confederation College and the Northern Interprofessional Collaboration for Health Education (NICHE), the North West

LHIN worked to improve access to interprofessional care. Through these forums, curriculum and training opportunities were identified.

Over the past year, we worked closely with local hospitals, HealthForceOntario, the Ministry of Health and Long-Term Care's Underserviced Area Program, and the regional locum pilot project to avert potential emergency department closures due to lack of physician coverage.

The North West LHIN also:

- Collaborated with HealthForceOntario's local Community Partnership Program Coordinator to support physician recruitment and emergency department coverage;
- Identified opportunities to improve and expand interprofessional practice in the Northwest by engaging the Health Professional Advisory Committee (HPAC); and
- Collaborated with academic partners to address current health human resource service gaps and rural practice realities.

Year Three of the Aging at Home Strategy had a positive impact on health human resources throughout the region. New initiatives required additional health human resource capacity, and offered an opportunity for providers to attract and retain valuable health human resources including:

- Additional personal support workers in long-term care and supportive housing services in Thunder Bay, Kenora, Rainy River, Dryden and Sioux Lookout;
- System coordinator position for Community Living in Marathon and Terrace Bay;
- System Navigator and Intensive Case Management positions at the Northwest Community Care Access Centre;
- Personal Support Workers at Wesway Respite Services; and,
- Registered Social Worker and seven Personal Support Workers for the Smooth Transitions program.

eHealth

The North West LHIN has advanced a number of regional eHealth initiatives to improve access to high quality health care, closer to home. We invested $353,971 in 14 organizations to upgrade or replace telemedicine equipment. The North West LHIN now has 137 Ontario Telemedicine Network (OTN) member sites that host close to 20,000 clinical telemedicine events a year.

As of March 2011, approximately 56 percent of family physicians have adopted the electronic medical record – third highest in the province, with a goal of 65 percent by next year. Twenty-three sites in the region are sharing pictures through a regional archiving communication system.

The increased integration of physician electronic medical records with hospital information systems now benefits more than 150,000 patients as information flows seamlessly between 12 hospitals, 26 clinics, connecting 169 doctors.

And working in partnership with four other LHINs and 22 local health service providers, the North West LHIN implemented the Ontario Common Assessment of Need (OCAN) tool and the Integrated Assessment Repository (IAR) through the *Doorways* project, an electronic portal that allows for the secure sharing and accessing of mental health assessment information.

Providers shared more than 1,700 patient records, allowing more time for client care and less time spent on administration.

As well, the North West LHIN has:

- Established a Project Management Office to guide eHealth projects and support health service providers in developing project management expertise;
- Launched its eHealth website; and
- Produced an eHealth newsletter, *Plugged In*.

Integration of Services along the Continuum of Care

Integration is a top priority for the North West LHIN. We are pursuing an integrated health system that supports a client-centred model of care where health service providers better link and coordinate care within and between sectors, across communities, districts and the region in Northwestern Ontario.

Over the past year, we have continued dialogue and challenged health service providers to consider various types of integration activities that will improve access to care and create a more sustainable health care system across our region.

In June 2010, the North West LHIN Board hosted a full-day *Integration Leadership Forum*, a knowledge exchange session with health leaders, CEOs and Board members from the various health service providers across the region. The session encouraged health service providers to use the North West LHIN Integration Framework and self-assessment tool to facilitate integration discussions within their organizations. Three additional governance-to-governance sessions on integration were scheduled to keep the dialogue going.

The North West LHIN also continued to build knowledge and capacity related to opportunities for integration through the hosting of governance-to-governance and leadership sessions with health service provider CEOs and Board members. Concrete and achievable goals for integration for 2011/2012 were identified through these education sessions.

Health service providers have also been encouraged to reference the *Governance Resource and Toolkit for Voluntary Integration Activities* and the *Self Assessment for Integration* documents.

In 2010/11, the North West LHIN revised its operational advisory team and committee structure to better integrate and align the cross-functional team membership and work of the committee.

As a result of this restructuring, we created the Integration Leadership Council in 2010. The Council brings together executive representation from various sectors including hospitals community support services, academia, long-term care, public health, business, municipal government, First Nations communities and Health Canada. The role of the Integration Leadership Council is to provide advice to the North West LHIN Senior Leadership team regarding matters of strategic importance, including but not limited to the ongoing implementation of the North West LHIN's *Integrated Health Services Plan*.

The Health Professional Advisory Committee, a mandatory committee of the North West LHIN, has been actively engaged in providing feedback on:

- The nine LHIN provincial priorities;
- Emergency Department/Alternate Level of Care;
- Health Services Blueprint;

- Integration Framework and Self-Assessment Tool;
- Interprofessional Team Practice; and
- Health human resource challenges across our region.

Additional committees of the North West LHIN include: the Aboriginal Health Services Advisory Committee, the eHealth Advisory Committee and the ED/Critical Care Advisory Committee.

Committee members bring a valuable clinical practice perspective to the ongoing work and planning priorities of the North West LHIN. The LHIN also met with various sector groups to discuss health care issues.

In 2010/11, the North West LHIN approved one voluntary integration activity related to back office support for a paymaster agreement. The integration reduced the administrative burden and better aligned accountability for the health service provider, while maintaining quality of care in the local community.

The North West LHIN Board also approved a hospital-led initiative to identify potential integration opportunities between three hospitals in our region: McCausland Hospital, Wilson Memorial General Hospital and Manitouwadge General Hospital.

In the past year, the North West LHIN facilitated a number of discussions between health services providers related to integration of services. For example, in the Kenora Rainy River District, community Mental Health and Addiction service providers have been meeting regularly with the North West LHIN staff and hospital sectors to examine opportunities for integration.

Clinical integration activities such as the initiation of the expanded role of the North West Community Care Access Centre (CCAC) in the assessment and placement of individuals within the supportive housing setting in Thunder Bay, began in 2010.

Since implementation of the Home First philosophy began in Thunder Bay in 2010, the North West CCAC expanded its role and responsibility for joint discharge planning and placement within the hospital setting.

Community Engagement

In 2010/11, the North West LHIN engaged 9,956 individuals, stakeholders and organizations at 852 sessions across the Northwest at forums, roundtable discussions, meetings, workshops and training, and through survey tools. That's a 75 percent increase of community engagement over the previous year.

Engagement focused on health planning priorities related to: mental health and addictions, emergency department wait times, Alternate Level of Care, chronic disease management, the Health Services Blueprint, quality improvement initiatives and LHIN activities.

We also engaged members of the Aboriginal community through CEO face-to-face meetings with Chiefs and Councils (more than 15 sessions), tribal councils, health advisory groups, health access centres, the Aboriginal Health Services Advisory Committee, Aboriginal health services providers and community health directors. Engagement efforts focused on identifying health needs, planning priorities and issues affecting Aboriginal people and communities in the North West LHIN.

In 2010/11, we advanced the development of an Aboriginal Community Engagement Strategy and the development of diversity indicators.

The North West LHIN continues to build capacity with the Aboriginal community related to the budget requirements, proposal development and report submissions.

We have heard through community engagement that the North West LHIN can help promote respect of traditional values, diversity and culturally sensitive and appropriate care amongst health service providers – and that more mental health and addictions education and training are required.

The North West LHIN community engagement activities included the Francophone population in our region. For example, interpretive resources were made available at community engagement sessions with health service providers in Geraldton.

This past year, we launched *LHINfo Minute* to keep Members of Provincial Parliament (MPPs) and municipal leaders informed on LHIN-wide accomplishments. We shared information broadly and regularly through presentations, the *LHINkages* newsletter and an up-to-date website.

And, in 2010/11, the North West LHIN worked with its other provincial LHIN partners and the Ministry of Health and Long-Term Care to establish the *LHIN Community Engagement Guidelines and Toolkit* (February, 2011), which has been shared widely with health care providers. This new framework provides input to the LHINs in terms of planning, resource allocation, community engagement priorities and strategies.

The community engagement tools are now incorporated into our project management toolkit, and a summary of engagement activity accomplishments will be posted on the North West LHIN website with the Annual Community Engagement Plan at www.northwestlhin.on.ca under Engaging our Communities.

Ministry-LHIN Accountability Agreement

The North West Local Health Integration Network (LHIN) and the Ministry of Health and Long-Term Care have negotiated an accountability agreement which defines the obligations and responsibilities of both the LHIN and the Ministry for the period 2010/11.

The agreement includes a number of schedules which outline how the LHIN is to carry out activities related to areas such as Community Engagement, Planning and Integration, Local Health System Management, Financial Management and Local Health System Performance and eHealth.

This type of agreement is mirrored in the accountability agreements that LHINs have already negotiated or are in the process of negotiating with health service providers such as hospitals, multi-sectoral agencies and the long-term care sector.

Report on MLPA Performance Indicators

The Ministry-LHIN Performance Agreement (MLPA) for 2010/11 sets out performance indicators and performance targets for the local health system. By setting these targets, the LHIN and Ministry are working towards improving the local health system performance and supporting the achievement of provincial targets.

In 2010/11, the LHIN improved on its performance compared to the previous year, reducing surgical wait times for cataracts, hip replacements and knee replacements at the 90th percentile to 86 days, 171 days and 183 days respectively. Wait times for CT scans remained low in 2010/11, with the wait at the 90th percentile decreasing from 28 days to 25 days. Wait times for MRI scans remains the fourth best in the province with a wait time at the 90th percentile of 86 days. In the area of cancer surgery, the LHIN continues to be a top performer in the province with a wait time at the 90th percentile of 37 days.

This past year, the LHIN saw an increase in the rate of Alternate Level of Care (ALC) patients in hospital from 17.86 percent to 22.67 percent. This increase is mainly attributed to a small number of long-stay ALC patients who were discharged from hospital. The LHIN expects the rate of ALC to decrease with additional investments in community-based health services and implementation of the Home First philosophy.

The two high-volume hospital sites in Kenora and Thunder Bay achieved an ALC rate of 18.6 percent which is three percent higher than our annual target. Alternate level of care pressures are closely monitored at these sites. We also know that the ALC definition does not work for small low-volume hospital sites in our region.

The North West LHIN saw continued strong performance in emergency department wait times for non-admitted patients. Wait times for non-admitted patients at the 90th percentile for low and high acuity patients were among the lowest in the province at 4.1 hours and 6.8 hours respectively. In 2010/11, the LHIN saw an increase in emergency department wait times for admitted patients from 27.2 hours to 31.5 hours. This increase was primarily due to a lack of patient flow within the Thunder Bay Regional Health Sciences Centre. It is anticipated that this wait time will decrease in 2011/12 with the implementation of Home First, resulting in fewer Alternate Level of Care patients being in hospital.

In 2010/11, the North West LHIN became accountable for repeat emergency department visit rates for mental health conditions, addictions conditions and re-admission rates for select medical conditions. For mental health, the LHIN saw the rate of repeat visits increase from 16.5 percent to 19.1 percent. For addictions, the rate of repeat visits decreased slightly from 29.7 percent to 29.4 percent. The rate of re-admission to hospital for select medical conditions increased from 15.8 percent to 19.0 percent. The LHIN is currently implementing strategies that aim to reduce all three of the indicators.

Table 2 outlines indicators measured in the North West LHIN in 2010/11.

Table 2

Performance Indicator	LHIN 10/11 Starting Point	LHIN 10/11 Target	Most Recent Quarter 10/11	Percent from Target for Most Recent Quarter Results*	Annual Results
1. 90th Percentile Wait Times for Cancer Surgery	40 days	45 days	37 days	-17.8%	39 days
2. 90th Percentile Wait Times for Cataract Surgery	106 days	106 days	86 days	-18.9%	103 days
3. 90th Percentile Wait Times for Hip Replacement	211 days	182 days	171 days	-6.0%	176 days
4. 90th Percentile Wait Times for Knee Replacement	246 days	182 days	183 days	0.5%	187 days
5. 90th Percentile Wait Times for Diagnostic MRI Scan	43 days	28 days	86 days	207.1%	66 days
6. 90th Percentile Wait Times for Diagnostic CT scan	28 days	28 days	25 days	-10.7%	25 days
7. Percentage of Alternate Level of Care Days - by LHIN of Institution* **	17.86%	15.40%	22.67%	47.2%	21.76%
8. 90th Percentile ER Length of Stay for Admitted Patients	27.2 hours	25.00 hours	31.55 hours	26.2%	28.83 hours
9. 90th Percentile ER Length of Stay for Non-Admitted Complex Patients	6.60 hours	6.60 hours	6.82 hours	3.3%	6.62 hours
10. 90th Percentile ER Length of Stay for Non-Admitted Minor Uncomplicated Patients	4.10 hours	4.00 hours	4.18 hours	4.6%	4.12 hours
11. Repeat Unplanned Emergency Visits Within 30 Days for Mental Health Conditions *(added 2010/11)***	16.50%	13.70%	19.14%	39.7%	17.19%
12. Repeat Unplanned Emergency Visits Within 30 Days for Substance Abuse Conditions *(added 2010/11)***	29.70%	22.20%	29.47%	32.8%	31.52%
13. Readmission Within 30 Days for Select CMG's *(added 2010/11)***	15.80%	14.80%	19.05%	28.7%	17.58%

*A negative percentage means the LHIN has met its target
**Fiscal Year 2010/11 is based on only 2 quarters of data (Q1-Q2 2010/11) due to availability
***Fiscal Year 2010/11 is based on only 3 quarters of data (Q1-Q3 2010/11) due to availability

LHIN-Initiatives in Support of Ministry Priorities

Emergency Department Wait Times & Alternate Level of Care

One of the greatest challenges faced by the North West LHIN over the past year is the increased number of patients waiting in the emergency department for admission to hospital, and increased numbers of Alternate Level of Care (ALC) patients occupying acute care beds.

All LHINs in the province identified nine provincial priorities to address emergency department wait times and escalating ALC days. The provincial LHIN priorities and initiatives were adopted by the North West LHIN.

Advancements in 2010 include:

- Supported hospitals to complete Quality Improvement Plans by providing updates and links to information on the North West LHIN website;
- Completed the Senior Friendly audit at all 13 hospital settings in the North West LHIN (goal to enhance the care of seniors within hospital settings);
- Implemented the Home First philosophy in Thunder Bay;
- Advanced the Provincial Falls Strategy through the work of the North West LHIN-Wide Falls Injury Prevention Collaborative and participation in the Residents First initiative;
- Facilitated discussions with health service providers about the establishment of a single, province-wide vision and framework to guide the development of new delivery models for rehabilitation and complex continuing care;
- Completed an analysis of patient populations determined to be Alternate Level of Care within two days of admission to hospital and an analysis of long-stay patient populations (> 318 and 550 days in hospital) as Alternate Level of Care to determine care needs and options for care in the community;
- Continued implementation of the Resource Matching and Referral system (streamlines and expedites the assessment and referral of patients between various health care settings) in Thunder Bay between the acute care setting, post-acute care setting, the North West Community Care Access Centre (CCAC) and long-term care settings;
- Worked with health service providers to improve the accuracy of reporting of emergency department wait times and alternate level of care data; and
- Advanced discussions and implemented the expanded role of the North West CCAC in management of the eligibility for wait lists in the supportive housing setting.

Through this work, the North West LHIN identified targeted initiatives that will help reduce emergency department wait times and Alternate Level of Care over the next fiscal year 2011/12.

Aging at Home Year Three

In Year Three (2010/11), the North West LHIN Aging at Home Strategy focused on four key objectives: providing additional

capacity for seniors' services, helping seniors avoid hospital admissions and return home safely after a hospital stay, creating enhanced community support services and developing outreach teams.

To meet these objectives, we continued funding successful initiatives including Smooth Transitions, additional interim long-term care beds in the City of Thunder Bay and assisted living services in Sioux Lookout, as well as funding supportive housing services in the City of Thunder Bay until the Centre of Excellence for Integrated Seniors' Services (CEISS) opens. We expanded community support services throughout the region, including the First Link program and respite services to the Districts of Kenora and Rainy River.

The Aging at Home Strategy in the North West LHIN allowed more than 5,000 seniors to receive services as close to home as possible and provided training to more than 500 front-line staff, including personal support workers in remote First Nations communities.

In 2010, the North West LHIN conducted a comprehensive evaluation of each Aging at Home initiative, utilizing the North West LHIN's decision-making framework.

This process involved reviewing actual performance against established targets, assessing the impact on the health care system, and identifying return on investment with an ultimate goal of ensuring that we are focusing not only on current system pressures but also on changing the health profile and behaviours of seniors within our system.

As a result of this evaluation, two initiatives were discontinued, 13 were time-limited and 16 initiatives continue to receive funding.

North West LHIN Special Initiatives

Health Services Blueprint

The North West LHIN embarked upon the development of a comprehensive Health Services Blueprint, a plan that will identify future models of health care delivery, opportunities for integration, and project the demand and capacity for health services, including planning priorities, for the North West LHIN out to 2021.

As part of the plan, we completed a literature review, qualitative and quantitative analysis is underway, and we hosted community engagement sessions in 12 communities across our region, engaging with about 700 individuals in a variety of ways. The plan will identify opportunities to improve coordination, integration and strategies for:

- Patient navigation and flow across the continuum of care;
- System transformation related to better and more effective and efficient ways to deliver service, while continuing to address population health care needs;
- Addressing service gaps and duplications;
- Improving service through use of existing resources; may include service expansion; or reducing service where the need no longer warrants it; or shifting services where another provider is in a better position to provide those services to the community;
- Improving value for money; and
- Eliminating redundancies where appropriate or enhancing services to fill a service gap.

At the conclusion of this project the Health Services Blueprint will provide the following:

- A detailed health services roadmap including recommendations on future models of care delivery, projected out to 2021;
- A detailed implementation plan to improve the coordination and integration of services;
- A comprehensive analysis of the interactions between current health service provider programs and services;
- A current and future state capacity analysis by sector to the year 2021, including assumptions related to future capacity, health human resources and infrastructure implications;
- An analysis of implications of proposed recommendations on current practice; and
- The development of an evaluation plan with proposed indicators, to measure system change and improvements to health outcomes.

North West LHIN's Operational Performance

The total number of staff at the North West LHIN as of March 31, 2011 was 28 FTE. The North West LHIN's operational budget was $5,031,192.

Financial statements of

North West Local Health Integration Network

March 31, 2011

North West Local Health Integration Network

March 31, 2011

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Independent Auditor's Report

To the Members of the Board of Directors of the
North West Local Health Integration Network

We have audited the accompanying financial statements of North West Local Health Integration Network, which comprise the statement of financial position as at March 31, 2011, and the statement of financial activities, changes in net debt and cash flows for the year then ended, and a summary of significant accounting policies and other explanatory information.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with Canadian public sector accounting standards, and for such internal control as management determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits in accordance with Canadian generally accepted auditing standards. Those standards require that we comply with ethical requirements and plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained in our audits is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the financial statements present fairly, in all material respects, the financial position of North West Local Health Integration network as at March 31, 2011 and the results of its financial activities, changes in its net debt and its cash flows for the years then ended in accordance with Canadian public sector accounting standards.

Deloitte & Touche LLP

Chartered Accountants
Licensed Public Accountants
June 28, 2011

North West Local Health Integration Network

Statement of financial position
as at March 31, 2011

	2011	2010
	$	$
Financial assets		
Cash	**668,646**	2,068,416
Due from Ministry of Health and Long Term Care ("MOHLTC")		
Health Service Provider ("HSP") transfer payments (Note 9)	**5,149,305**	555,356
Due from MOHLTC - Internal LHIN Project Funding	**-**	90,000
Accounts receivable	**102,093**	-
Due from HNHB LHIN	**-**	12,057
	5,920,044	2,725,829
Liabilities		
Accounts payable and accrued liabilities	**571,855**	1,064,569
Due to HSPs (Note 9)	**5,149,305**	555,356
Due to MOHLTC (Note 3)	**203,112**	1,110,536
Due to the LHIN Shared Services Office (Note 4)	**1,784**	1,971
Deferred capital contributions (Note 5)	**389,100**	99,613
	6,315,156	2,832,045
Commitments (Note 6)		
Net debt	**(395,112)**	(106,216)
Non-financial assets		
Capital assets (Note 7)	**389,100**	99,613
Prepaid expenses	**6,012**	6,603
Accumulated surplus	**-**	-

Approved by the Board

Director

Director

North West Local Health Integration Network

Statement of financial activities
year ended March 31, 2011

	Budget (unaudited) (Note 8)	2011 Actual	2010 Actual
	$	$	$
Revenue			
MOHLTC funding			
HSPs transfer payments (Note 9)	**546,111,700**	**587,667,411**	567,492,550
Operations of LHIN	**4,956,792**	**4,806,240**	4,864,099
Aboriginal Community Engagement (Note 11)	**160,000**	**160,000**	160,000
E-Health (Note 12)	**600,000**	**760,000**	655,000
Emergency Department ("ED")			
LHIN Lead (Note 13)	-	**75,000**	75,000
Critical Care ("CC") LHIN Lead (Note 18)	-	**75,000**	-
Ontario Diabetes Strategy ("ODS") (Note 14)			
ODS Service Expansion	-	-	66,500
ODS High Risk Populations	-	-	54,500
ODS Self-management Capacity Building	-	-	35,000
Emergency Room/Alternative Level of Care			
("ER/ALC") Performance Lead (Note 15)	-	**100,000**	100,000
Aboriginal Health Transition (Note 16)	-	-	422,125
Francophone Community Engagement (Note 17)	-	**74,670**	77,700
Amortization of deferred capital			
contributions (Note 5)	-	**110,465**	162,855
	551,828,492	**593,828,786**	574,165,329
Expenses			
Transfer payments to HSPs (Note 9)	**546,111,700**	**587,667,411**	567,492,550
General and administrative (Note 10)	**4,956,792**	**4,733,985**	4,752,093
Aboriginal Community Engagement (Note 11)	**160,000**	**150,374**	20,964
E-Health (Note 12)	**600,000**	**760,000**	398,839
ED LHIN Lead (Note 13)	-	**75,000**	70,616
CC LHIN Lead (Note 18)	-	**75,000**	-
Ontario Diabetes Strategy (Note 14)	-	-	-
ODS Service Expansion	-	-	66,500
Emergency Room/Alternative Level of Care			
("ER/ALC") Performance Lead (Note 15)	-	**22,000**	-
Aboriginal Health Transition (Note 16)	-	-	312,504
Francophone Community Engagement (Note 17)	-	**63,904**	-
	551,828,492	**593,547,674**	573,114,066
Annual surplus before funding repayable to MOHLTC	-	**281,112**	1,051,263
Funding repayable to the MOHLTC (Note 3)		**(203,112)**	(848,780)
In year surplus recovered by MOHLTC (Note 3)	-	**(78,000)**	(202,483)
Annual surplus	-	-	-
Opening accumulated surplus	-	-	-
Closing accumulated surplus	-	-	-

North West Local Health Integration Network

Statement of changes in net debt
year ended March 31, 2011

	2011	2010
	$	$
Annual surplus	-	-
Decrease (increase) in prepaid expenses	**591**	(6,603)
Acquisition of capital assets	**(399,953)**	(92,693)
Amortization of capital assets	**110,465**	162,855
(Decrease) increase in net debt	**(288,896)**	63,559
Opening net debt	**(106,216)**	(169,775)
Closing net debt	**(395,112)**	(106,216)

North West Local Health Integration Network

Statement of cash flows

year ended March 31, 2011

	2011	2010
	$	$
Operating		
Annual surplus	-	-
Less items not affecting cash		
Amortization of capital assets	**110,465**	162,855
Amortization of deferred capital contributions (Note 5)	**(110,465)**	(162,855)
	-	-
Changes in non-cash operating items		
(Increase) decrease in due from MOHLTC - HSPs transfer payments	**(4,593,949)**	1,024,524
Decrease (increase) in due from MOHLTC - Internal LHIN Project Funding	**90,000**	(90,000)
Decrease (increase) in due from HNHB LHIN	**12,057**	(12,057)
Increase in accounts receivable	**(102,093)**	-
(Decrease) increase in accounts payable	**(492,715)**	43,976
Increase (decrease) in due to HSPs	**4,593,949**	(1,024,524)
(Decrease) increase in due to MOHLTC	**(907,423)**	692,738
Decrease in due to LHIN Shared Services Office	**(187)**	(30,308)
Decrease (increase) in Prepaid expenses	**591**	(6,603)
	(1,399,770)	597,746
Capital transactions		
Acquisition of capital assets	**(399,953)**	(92,693)
Financing transactions		
Increase in deferred capital contributions (Note 5)	**399,953**	92,693
Net (decrease) increase in cash	**(1,399,770)**	597,746
Cash, beginning of year	**2,068,416**	1,470,670
Cash, end of year	**668,646**	2,068,416

North West Local Health Integration Network

Notes to the financial statements

March 31, 2011

1. Description of business

The North West Local Health Integration Network was incorporated by Letters Patent on June 16, 2005 as a corporation without share capital. Following Royal Assent to Bill 36 on March 28, 2006, it was continued under the *Local Health System Integration Act, 2006* (the "Act") as the North West Local Health Integration Network (the "LHIN") and its Letters Patent were extinguished. As an agent of the Crown, the LHIN is not subject to income taxation.

The LHIN is, and exercises its powers only as, an agent of the Crown. Limits on the LHIN's ability to undertake certain activities are set out in the Act.

The LHIN has also entered into an Accountability Agreement with the Ministry of Health and Long Term Care ("MOHLTC"), which provides the framework for LHIN accountabilities and activities.

Commencing April 1, 2007, all funding payments to LHIN managed health service providers in the LHIN geographic area, have flowed through the LHIN's financial statements. Funding allocations from the MOHLTC are reflected as revenue with an equal amount of transfer payments to authorized Health Service Providers ("HSP") expensed in the LHIN's financial statements for the year ended March 31, 2011.

The mandates of the LHIN are to plan, fund and integrate the local health system within its geographic area. The LHIN spans carefully defined geographical areas and allows for local communities and health care providers within the geographical area to work together to identify local priorities, plan health services and deliver them in a more coordinated fashion. The LHIN covers the Districts of Thunder Bay, Rainy River and most of Kenora. The LHIN enters into service accountability agreements with service providers.

2. Significant accounting policies

The financial statements of the LHIN are the representations of management, prepared in accordance with Canadian generally accepted accounting principles for governments as established by the Public Sector Accounting Board ("PSAB") of the Canadian Institute of Chartered Accountants ("CICA") and, where applicable, the recommendations of the Accounting Standards Board ("AcSB") of the CICA as interpreted by the Province of Ontario. Significant accounting policies adopted by the LHIN are as follows:

Basis of accounting

Revenues and expenses are reported on the accrual basis of accounting. The accrual basis of accounting recognizes revenues in the fiscal year that the events giving rise to the revenues occur and they are earned and measurable; expenses are recognized in the fiscal year that the events giving rise to the expenses are incurred, resources are consumed, and they are measurable.

Through the accrual basis of accounting, expenses include non-cash items, such as the amortization of capital assets and impairments in the value of assets.

Ministry of Health and Long-Term Care Funding

The LHIN is funded solely by the Province of Ontario in accordance with the Ministry LHIN Accountability Agreement ("MLAA"), which describes budget arrangements established by the MOHLTC. These financial statements reflect agreed funding arrangements approved by the MOHLTC. The LHIN cannot authorize an amount in excess of the budget allocation set by the MOHLTC.

The LHIN assumed responsibility to authorize transfer payments to Health Service Providers ("HSPs"), effective April 1, 2007. The transfer payment amount is based on provisions associated with the respective HSP Accountability Agreement with the LHIN. Throughout the fiscal year, the LHIN authorizes and notifies the MOHLTC of the transfer payment amount; the MOHLTC, in turn, transfers the amount directly to the HSP. The cash associated with the transfer payment does not flow through the LHIN bank account.

The LHIN statements do not include any MOHLTC managed programs.

2. Significant accounting policies (continued)

Government transfer payments

Government transfer payments from the MOHLTC are recognized in the financial statements in the year in which the payment is authorized and the events giving rise to the transfer occur, performance criteria are met, and reasonable estimates of the amount can be made.

Certain amounts, including transfer payments from the MOHLTC, are received pursuant to legislation, regulation or agreement and may only be used in the conduct of certain programs or in the completion of specific work. Funding is only recognized as revenue in the fiscal year the related expenses are incurred or services performed. In addition, certain amounts received are used to pay expenses for which the related services have yet to be performed. These amounts are recorded as payable to the MOHLTC at period end.

Deferred capital contributions

Any amounts received that are used to fund expenditures that are recorded as capital assets, are recorded as deferred capital contributions and are recognized as revenue over the useful life of the asset reflective of the provision of its services. The amount recorded under "revenue" in the Statement of Financial Activities, is in accordance with the amortization policy applied to the related capital asset recorded.

Capital assets

Capital assets are recorded at historic cost. Historic cost includes the costs directly related to the acquisition, design, construction, development, improvement or betterment of capital assets. The cost of capital assets contributed is recorded at the estimated fair value on the date of contribution. Fair value of contributed capital assets is estimated using the cost of asset or, where more appropriate, market or appraisal values. Where an estimate of fair value cannot be made, the capital asset would be recognized at nominal value.

Maintenance and repair costs are recognized as an expense when incurred. Betterments or improvements that significantly increase or prolong the service life or capacity of a capital asset are capitalized. Computer software is recognized as an expense when incurred.

Capital assets are stated at cost less accumulated amortization. Capital assets are amortized over their estimated useful lives as follows:

Office furniture and fixtures	5 years straight-line method
Computer equipment	3 years straight-line method
Leasehold improvements	Life of lease straight-line method
Web development	3 years straight-line method

For assets acquired or brought into use during the year, amortization is provided for a full year.

Segmented information

A segment is defined as a distinguishable activity or group of activities for which it is appropriate to separately report financial information. Management has determined that existing disclosures in the Statement of Financial Activities and within the related notes for both the prior and current year sufficiently disclose information for all appropriate segments and therefore no additional disclosure is required.

Use of estimates

The preparation of financial statements in conformity with Canadian generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amount of assets and liabilities, the disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

3. Funding repayable to the MOHLTC

In accordance with the MLAA, the LHIN is required to be in a balanced position at year end. Thus, any funding received in excess of expenses incurred, is required to be returned to the MOHLTC.

The amount repayable to the MOHLTC related to the current year activities is made up of the following components:

	Revenue	Expenses	2011 surplus	2010 surplus
	$	$	$	$
Transfer payments to HSPs	587,667,411	587,667,411	-	-
LHIN operations	4,916,705	4,733,985	182,720	274,861
Aboriginal Community Engagement	160,000	150,374	9,626	139,036
E-Health	760,000	760,000	-	256,161
ED LHIN Lead	75,000	75,000	-	4,384
Critical Care ("CC") LHIN Lead	75,000	75,000	-	-
Ontario Diabetes Strategy (ODS)				
ODS High Risk Populations	-	-	-	54,500
ODS Self-Management Capacity Building	-	-	-	35,000
ER/ALC Performance Lead	100,000	22,000	78,000	100,000
Aboriginal Health Transition	-	-	-	109,621
Francophone Community Engagement	74,670	63,904	10,766	77,700
	593,828,786	593,547,674	281,112	1,051,263

The amount due to the MOHLTC at March 31 is made up as follows:

	2011	2010
	$	$
Due to MOHLTC, beginning of year	1,110,536	417,798
Funding repaid to MOHLTC	(1,110,536)	(6,417)
Aboriginal Health Transition carryforward (Note 16)	-	(149,625)
Funding repayable to the MOHLTC related to current year activities	281,112	1,051,263
In year surplus recovered by MOHLTC	(78,000)	(202,483)
Due to MOHLTC, end of year	203,112	1,110,536

4. Related party transactions

The LHIN Shared Services Office (the "LSSO") and the Local Health Integration Network Collaborative (the "LHINC") are divisions of the Toronto Central LHIN and are subject to the same policies, guidelines and directives as the Toronto Central LHIN. The LSSO and LHINC, on behalf of the LHINs are responsible for providing services to all LHINs. The full costs of providing these services are billed to all the LHINs. Any portion of the LSSO operating costs overpaid (or not paid) by the LHIN at the year end are recorded as a receivable (payable) from (to) the LSSO. This is all done pursuant to the shared service agreement the LSSO has with all LHINs.

5. Deferred capital contributions

	2011	2010
	$	$
Balance, beginning of year	**99,613**	169,775
Capital contributions received during the year	**399,952**	92,693
Amortization for the year	**(110,465)**	(162,855)
Balance, end of year	**389,100**	99,613

6. Commitments

The LHIN has commitments under various operating leases related to building and equipment extending to 2016. Lease renewals are likely. Minimum lease payments due in each of the next five years are as follows:

	$
2012	240,558
2013	223,437
2014	222,927
2015	219,457
2016	54,715
	961,094

The LHIN also has funding commitments to HSPs associated with accountability agreements. Minimum commitments to HSPs related to the next two years, based on the current accountability agreements, are as follows:

	$
2012	568,309,039
2013	171,074,095

The actual amounts which will ultimately be paid are contingent upon actual LHIN funding received from the MOHLTC.

7. Capital assets

			2011	2010
	Cost	Accumulated amortization	Net book value	Net book value
	$	$	$	$
Office furniture and fixtures	**297,086**	**249,709**	**47,377**	35,295
Computer equipment	**125,166**	**99,689**	**25,477**	36,027
Leasehold improvements	**884,628**	**568,383**	**316,245**	28,125
Web development	**7,250**	**7,250**	**-**	166
	1,314,132	**925,032**	**389,100**	99,613

8. Budget figures

The budgets were approved by the Government of Ontario. The budget figures reported in the Statement of financial activities reflect the initial budget. The figures have been reported for the purposes of these statements to comply with PSAB reporting principles. During the year the government approved budget adjustments. The following reflects the adjustments for the LHIN during the year:

The final HSP funding budget of $587,667,411 is derived as follows:

	$
Initial HSP funding budget	546,111,700
Adjustment due to announcements made during the year	41,555,711
Final HSP funding budget	587,667,411

The final LHIN budget excluding the HSP funding budget of $5,875,909 is derived as follows:

	$
Initial budget	5,716,792
Additional funding received during the year	
Stabilization increase for 2010/11	74,400
E-Health	160,000
ED LHIN Lead	75,000
Critical Care Lead	75,000
ER/ALC Performance Lead	100,000
French Language Services	74,670
Amount treated as capital contributions made during the year	(399,953)
Final budget	5,875,909

9. Transfer payments to HSPs

The LHIN has authorization to allocate funding of $587,667,411 to the various HSPs in its geographic area. The LHIN approved transfer payments to the various sectors as follows:

	2011	2010
	$	$
Operation of hospitals	**408,839,069**	397,171,734
Health Infrastructure Renewal Fund	**3,600,688**	3,691,453
Grants to compensate for municipal taxation - public hospitals	**104,250**	104,250
Long term care homes	**63,272,414**	61,503,112
Community care access centres	**39,768,960**	37,733,336
Community support services	**12,860,141**	12,283,665
Acquired brain injury	**1,790,490**	1,205,225
Assisted living services in supportive housing	**6,495,038**	5,230,389
Community health centres	**8,078,314**	7,155,135
Community mental health program	**30,639,650**	29,615,269
Addictions program	**12,218,397**	11,798,982
	587,667,411	567,492,550

The LHIN receives funding from the MOHLTC and in turn allocates it to the HSPs. As at March 31, 2011, an amount of $5,149,305 (2010 - $555,356) was receivable from the MOHLTC, and $5,149,305 (2010 - $555,356) was payable to the HSPs. These amounts have been reflected as revenue and expenses in the Statement of financial activities and are included in the table above.

10. General and administrative expenses

The Statement of financial activities presents expenses by function. The following classifies general and administrative expenses by object:

	2011	2010
	$	$
Salaries and benefits	**2,761,176**	3,117,354
Occupancy	**217,535**	191,212
Amortization	**110,465**	162,855
Equipment and maintenance	**64,571**	47,487
Shared services	**359,497**	362,714
Public relations and community forums	**11,680**	55,209
Professional fees	**21,520**	14,500
Travel	**131,757**	212,848
Staff development and recruitment	**142,565**	104,377
Consulting services	**461,446**	75,817
LHIN collaborative	**50,000**	12,286
Supplies, printing and office	**92,712**	111,337
Other board member per diems	**74,265**	58,705
Board chair per diems	**39,725**	43,610
Other governance and travel costs	**126,520**	113,005
Mail, courier and telecommunications	**68,551**	68,777
	4,733,985	4,752,093

11. Aboriginal Community Engagement

The Ministry of Health and Long-Term Care provided $160,000 (2010 - $160,000) in additional base operational funding which was annualized for the purposes of engaging the Aboriginal population and organizations in the North West LHIN. During 2011, $150,374 (2010 - $20,964) of expenses were incurred.

12. E-Health

The E-Health office of the Ministry of Health and Long-Term Care provided $760,000 (2010 - $655,000) to the LHIN. The funds were used to cover the operational and project costs associated with the LHIN Project Management Office infrastructure and E-Health Ontario activities. During the year, $760,000 (2010 - $398,839) of expenses were incurred.

13. Emergency Department LHIN Lead

The Ministry of Health and Long-Term Care provided $75,000 (2010 - $75,000) in one-time funding to support the compensation of the North West LHIN Emergency Department (ED) LHIN Lead. During the year, $75,000 of expenses were incurred (2010 - $70,616).

14. Ontario Diabetes Strategy ("ODS")

ODS Service Expansion

The funding for the Diabetes implementation was discontinued in 2011 (2010 - $66,500) and there were no expenses incurred (2010 - $66,500).

ODS High Risk Populations

The funding for the High Risk Populations was discontinued in 2011 (2010 - $54,500) and there were no expenses incurred (2010 - $0).

ODS Self-management Capacity Building

The funding to support the implementation of the Self-Management Capacity Building Initiative was discontinued in 2011 (2010 - $35,000) and there were no expenses incurred (2010 - $0).

15. ER/ALC Performance Lead

The Ministry of Health and Long-Term Care provided one-time funding in the amount of $100,000 (2010 - $100,000) to support the compensation of the LHIN ER/ALC Performance Lead in 2010/11. During the year, $22,000 (2010 - $0) of expenses were incurred. $78,000 was recovered as surplus during the year.

16. Aboriginal Health Transition

The funding to support the Aboriginal Health Transition Fund Projects was discontinued in 2011 (2010 - $422,125) and there were no expenses incurred (2010 - $312,504).

17. French Language Services

The Ministry of Health and Long-Term Care approved one-time funding of $74,670 (2010 - $77,700) to support the LHIN in its French Language Services activities. During the year, $63,904 (2010 - $0) of expenses were incurred.

18. Critical Care Lead

The Ministry of Health and Long-Term Care provided one-time funding in the amount of $75,000 (2010 - $0) to support the compensation of the LHIN Critical Care Lead in 2010/11. During the year, $75,000 (2010 - $0) of expenses were incurred.

19. Pension agreements

The LHIN makes contributions to the Hospitals of Ontario Pension Plan ("HOOPP"), which is a multi-employer plan, on behalf of approximately 24 members of its staff. The plan is a defined benefit plan, which specifies the amount of retirement benefit to be received by the employees, based on the length of service and rates of pay. The amount contributed to HOOPP for fiscal 2011 was $204,724 (2010 - $265,961) for current service costs and is included as an expense in the Statement of Financial Activities. The last actuarial valuation was completed for the plan in December 31, 2010. At that time, the plan was fully funded.

20. Guarantees

The LHIN is subject to the provisions of the *Financial Administration Act*. As a result, in the normal course of business, the LHIN may not enter into agreements that include indemnities in favour of third parties, except in accordance with the *Financial Administration Act* and the related Indemnification Directive.

An indemnity of the Chief Executive Officer was provided directly by the LHIN pursuant to the terms of the *Local Health System Integration Act, 2006* and in accordance with s. 28 of the *Financial Administration Act*.